

➤ **PLEASE FILL OUT COMPLETELY. PLEASE PRINT.**

➤ **FAILURE TO DO SO MAY DELAY CONSIDERATION OF YOUR CLAIM.**

IDENTIFYING INFORMATION

Applicant's Name _____ Today's Date _____

Male ☐ Female ☐ Age _____

Date of Birth	--- --	---	---	Social Security #	--- --	---	---
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When did your disability start? _____

What is your disability? _____

How does it affect working or doing other activities? _____

EDUCATION

Highest Grade Completed	Date Last Attended (year)	Did you attend:
-----	-----	Special Education Classes Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, When _____ Where? _____ Vocational School Yes <input type="checkbox"/> (what type?) _____ Other Training Yes <input type="checkbox"/> (what type?) _____

WORK HISTORY (GO BACK 15 YEARS. ATTACH ADDITIONAL PAGES AS NEEDED). Place a circle around any Jobs/Duties that you believe you can do now.

[illegible]

ACTIVITIES

Place a check in each box for activities you can do on any given day or on a regular basis, without assistance?

Yard Work <input type="checkbox"/>	Light Housekeeping <input type="checkbox"/>	Cook/ Prepare Meal <input type="checkbox"/>
Drive <input type="checkbox"/>	Pay Bills <input type="checkbox"/>	Shop <input type="checkbox"/>
Child Care <input type="checkbox"/>	Care for Pets/ Animals <input type="checkbox"/>	Daily Hygiene (bathe, etc.) <input type="checkbox"/>
Take Medication <input type="checkbox"/>	Attend Church <input type="checkbox"/>	Talk on Phone <input type="checkbox"/>
Use Computer <input type="checkbox"/>	Social Activities <input type="checkbox"/>	Care for Elderly / Others <input type="checkbox"/>
Keep a Checkbook <input type="checkbox"/>	Make Purchases <input type="checkbox"/>	Count Change <input type="checkbox"/>

For things you did not check above, who helps you with the activity and how? _____

When going out, how do you travel?

Walk <input type="checkbox"/>	Drive a Car <input type="checkbox"/>	Ride a Bike <input type="checkbox"/>	Ride in a Car <input type="checkbox"/>	Public Transportation <input type="checkbox"/>
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List the places you go on a regular basis _____

Do you use any assistive device and if so what type? (cane, wheelchair, walker, other) _____

How often do you use the assistive device above? ☐ Seldom ☐ Frequently ☐ Always

Was the assistive device prescribed? Yes ☐ No ☐ **If Yes**, by whom? _____

What are your hobbies and interests? (Examples are, reading, TV, playing sports, sewing, etc.)

Do you have problems getting along with family, friends, or neighbors? Yes ☐ No ☐

If Yes, explain. _____

ABILITIES

Check any of the following that your illness, injury, or condition affects:

Understand Directions <input type="checkbox"/>	Complete Tasks <input type="checkbox"/>	Stand for 30 Minutes <input type="checkbox"/>
Handle Change in Routine <input type="checkbox"/>	Get Along with Others <input type="checkbox"/>	Sit for an Hour <input type="checkbox"/>
Get Along with Authority <input type="checkbox"/>	Handle Stress <input type="checkbox"/>	Bend or Stoop Down <input type="checkbox"/>
Follow Spoken Instructions <input type="checkbox"/>	Concentrate <input type="checkbox"/>	Walk a Block <input type="checkbox"/>
Follow Written Directions <input type="checkbox"/>	See (w/glasses if needed) <input type="checkbox"/>	Other: _____ <input type="checkbox"/>
Remember Routine Things <input type="checkbox"/>	Hear (w/aid if needed) <input type="checkbox"/>	

HEALTHCARE INFORMATION (USE ADDITIONAL PAGES AS NEEDED)

List all doctors, hospitals and clinics where you have received treatment. Send all medical records pertaining to your disability for services received. (Within the last 24 months for a physical disability and all records for a psychological disability). If we have to request your medical records we will need you to sign a release form for each provider.

Doctor / Hospital / Clinic	Address & Phone #	Dates Treated		Reason for Treatment
		From	To	

MEDICATIONS (USE ADDITIONAL PAGES AS NEEDED)

List all of the medications that you currently take and list the doctor who prescribes each.

Name of Medicine	Dosage & How Often Taken	Who Prescribed	Date of Last Visit with this Provider

OTHER ELIGIBILITY

Place an 'X' in any column in which you applied for, or are receiving services or benefits from the programs listed below. <u>If benefit has been denied or terminated, please list the date.</u>	Applied For	Approved	Pending	Appealed	Denied (date)	Terminated (date)
Vocational Rehabilitation (VR) (Please send a copy of your VR Plan)						
SSI/ Social Security Disability (SSDI) (Please send a copy of the decision notice from social security)						

If Supplemental Security Income (SSI) or Social Security Disability (SSDI) was denied or terminated, give the reason for denial or termination _____

OTHER INFORMATION

Is there any other information that you want us to know about your claim? _____

SOURCES OF INFORMATION

Print name of person who filled out this form: (If other than applicant, print relationship)

NAME OF PERSON COMPLETING THIS FORM

RELATIONSHIP TO APPLICANT

AGENCY REPRESENTATIVE CONDUCTING INTERVIEW (IF APPLICABLE)

(For Face to Face interviews only) Describe any significant information, such as physical appearance, symptoms, handicaps, mental attitude, etc. If unable to interview the applicant directly, explain why.

Agency Representative (*Print Name*)

Agency

Date